SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Admiral Life Insurance Company of America

Product Name: AL AR Rev Application Filing	SERFF Tr Num: WKLY-125964883	State: ArkansasLH
TOI: MS06 Medicare Supplement - Other	SERFF Status: Closed	State Tr Num: 41227
Sub-TOI: MS06.000 Medicare Supplement - Other	Co Tr Num: AL AR REV APP FILING	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Stephanie Fowler
	Author: Karen Nowlan	Disposition Date: 01/20/2009
	Date Submitted: 12/24/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/20/2009	
State Status Changed: 01/20/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Revised Med Sup Application Filing

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAI01)

Karen Nowlan, Compliance Analyst karen.nowlan@wakelyinc.com

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Wakely and Associates, Inc.
Largo, FL 33773-1502
(727) 584-8128 [Phone]
(727) 584-5613[FAX]

Filing Company Information

Admiral Life Insurance Company of America
One State Mutual Drive
Rome, GA 30165
(800) 987-1593 ext. [Phone]

CoCode: 71390
Group Code: 4172
Group Name:
FEIN Number: 41-6041001

State of Domicile: Arizona
Company Type:
State ID Number:

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
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Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	1 form X $ 20.00 = $20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Admiral Life Insurance Company of America	$20.00	12/24/2008	24711088

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	01/20/2009	01/20/2009

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
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TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/20/2009
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Ltr of Authorization	Accepted for Informational Purposes	Yes
Supporting Document	NAIC Transmittal	Accepted for Informational Purposes	Yes
Form	Application	Approved	Yes

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: ALMSAPP200812AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	ALMSAPP200812AR	Application/ Enrollment Form	Application	Revised	Replaced Form #: MSAPP200701AR Previous Filing #: WKLY-125307727		ALMSAPP200812AR.pdf

ADMIRAL LIFE INSURANCE COMPANY OF AMERICA

Home Office: Phoenix, AZ 85010 **Administration: P.O. Box 10862 Clearwater, Florida 33757-8862**

APPLICATION #:

APPLICANT*(Exactly as shown on your Medicare ID Card)*

Last *First* *MI*

Check the Medicare Supplement Plan You Prefer:

- ☐ **Standardized Plan A**
- ☐ **Standardized Plan B**
- ☐ **Standardized Plan C**
- ☐ **Standardized Plan D**
- ☐ **Standardized Plan E**
- ☐ **Standardized Plan F**
- ☐ **Standardized Plan G**

RESIDENCE ADDRESS

Street:

City:

State: *Zip Code:*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

AREA CODE	TELEPHONE NUMBER

SOCIAL SECURITY NUMBER

MEDICARE INFORMATION

Medicare Part A Effective Date: _____

Medicare Part B Effective Date: _____

Medicare Claim Number: _____

Effective Date: **Special Requests:**

Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant If not answered, policy will mailed to Agent.

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past five years?

☐ Yes ☐ No

(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

MODAL PREMIUM: **$**_____

TOTAL INITIAL PREMIUM: **$** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft* ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

***Draft Preference:** ☐ Draft on Effective Date ☐ Draft on Issue If not answered, will draft on issue.

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-12 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-11, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1.	Are you bedridden or do you require the assistance of a wheelchair or motorized mobility aid?	☐ Yes	☐ No
2.	Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?	☐ Yes	☐ No
3.	Are you currently confined to a hospital, nursing facility or have you been hospitalized two or more times in the past year?	☐ Yes	☐ No
4.	Are you currently using the services of a home health care agency?	☐ Yes	☐ No
5.	Has surgery, treatment, therapy, or tests been advised by a physician but not performed?	☐ Yes	☐ No
6.	Within the past two years have you had an amputation caused by disease?	☐ Yes	☐ No
7.	Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following conditions:		
	a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, Organic Brain Syndrome, Senile Dementia, or other senility disorder?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection? ☐ Yes ☐ No

c. Diabetes that has ever required more than 50 units of insulin daily? ☐ Yes ☐ No

d. Diabetes in addition to any of the following: diabetic retinopathy, Peripheral Vascular Disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? ☐ Yes ☐ No

e. Do you have Renal Failure or any Kidney Disease requiring dialysis? ☐ Yes ☐ No

f. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition? ☐ Yes ☐ No

g. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? ☐ Yes ☐ No

h. Congestive Heart Failure (CHF), or Peripheral Vascular Disease? ☐ Yes ☐ No

i. Osteoporosis with fracture? ☐ Yes ☐ No

8. Within the past two years have you had a heart attack, a Stroke, or a Transient Ischemic Attack (TIA), heart or heart valve surgery, a cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device? ☐ Yes ☐ No

9. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, Paget's Disease, Lupus, Rheumatoid Arthritis, or Disabling Arthritis? ☐ Yes ☐ No

10. Have you been advised to have a joint replacement? ☐ Yes ☐ No

11. Have you had an organ transplant or been advised to have an organ transplant? ☐ Yes ☐ No

12. Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary. ☐ Yes ☐ No

Prescription Medication Name	Frequency and Dosage	**Diagnosis/Condition

ALL PRESCRIPTION MEDICATIONS CURRENTLY BEING TAKEN MUST BE LISTED.

**** IN THE DIAGNOSIS/CONDITION COLUMN, WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER ARE NOT ACCEPTABLE. THE MEDICAL CONDITIONS OR DIAGNOSIS FOR THE MEDICATION MUST BE LISTED.**

Primary Physician Information

Name:

Address:

Telephone:

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

   IF YES,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   If yes, what company _____

   Company telephone number _____ Policy number _____

   (c) Was this your first time in this type of plan (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, with what company and what kind of policy?

   _____

   Company telephone number _____ Policy number _____

   (b) What are your dates of coverage under the other policy? START __/__/__ END __/__/__

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-12 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual; or the individual leaves the plan, whether the plan is primary or secondary with Medicare; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon first becoming eligible for benefits under Part A at age 65, enrolled in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Admiral Life Insurance Company of America, or its reinsurers, any such information. I understand that I am authorizing Admiral Life Insurance Company of America to receive my health information, prescription drug usage history and my non-medical information. The released information received by Admiral Life Insurance Company of America will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Admiral Life Insurance Company of America. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Admiral Life Insurance Company of America *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Admiral Life Insurance Company of America in writing at their Medicare Supplement Administrative Office: P.O. Box 10860, Clearwater, Florida 33757-8860. I understand that such revocation will not have any effect on actions Admiral Life Insurance Company of America took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature: _____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent's Signature:	**Date:**
Agent's Printed Name:	**Agent No.:**

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
Company Tracking Number:	*AL AR REV APP FILING*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Accepted for Informational Purposes 01/20/2009

Comments:

Attachments:

AR Certificate of Compliance.pdf

NAIC Transmittal 2.pdf

Bypassed -Name: Application

Review Status: 12/24/2008

Bypass Reason: Please see Form Tab

Comments:

Bypassed -Name: Health - Actuarial Justification

Review Status: 12/24/2008

Bypass Reason: NA - rates are not affected by this filing

Comments:

Bypassed -Name: Outline of Coverage

Review Status: 12/24/2008

Bypass Reason: NA This is a revised application filing

Comments:

Satisfied -Name: Ltr of Authorization

Review Status: Accepted for Informational Purposes 01/20/2009

Comments:

Attachment:

2008 02 Admiral Authorization Letter.pdf

Satisfied -Name: NAIC Transmittal

Review Status: Accepted for Informational 01/20/2009

SERFF Tracking Number:	*WKLY-125964883*	*State:*	*Arkansas*
Filing Company:	*Admiral Life Insurance Company of America*	*State Tracking Number:*	*41227*
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Product Name:	*AL AR Rev Application Filing*		
Project Name/Number:	*/*		

Purposes

Comments:

NAIC TRANSMITTAL

Attachment:

NAIC Transmittal 2.pdf

ARKANSAS COMPLIANCE CERTIFICATION

Name and Address of Insurer:

Admiral Life Insurance Company of America
2999 N 44th Street, Suite 250
Phoenix, AZ

The Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted complies with the requirements of Rules and Regulation 19; Rule and Regulation 49, and ACA 23-79-138 and Bulletin 11-88.

Signed for the Company by an Officer

Title: Corporate Secretary

Date: December 19, 2008

Effective January 1, 2006

Life, Accident & Health, Annuity, Credit Transmittal Document (Revised 1/1/06)

Reset Form

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #
Admiral Life Insurance Company of America 2999 N 44th Street, Suite 250 Phoenix, AZ	Arizona	Life and Health	4172	71390	41-6041001

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Karen Nowlan Wakely and Associates, Inc. 8545 126th Avenue, North Largo, FL 33773-1502	877-777-2443, ext 2171	727-584-5613	karen.nowlan@wakelyinc.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain) : _____

6a.	Company Tracking Number		6b.	SERFF Tracking Number	WKLY-125964883
7.	☑ New Submission	☐ Resubmission	Previous file # _____		
8.	Market	☑ Individual ☐ Franchise			
		Group	☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____		
9.	Type of Insurance	MS06 Medicare Supplement-Other			
10.	Product Coding Matrix Filing Code	MS06.000 Medicare Supplement-Other			

11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☑ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☑ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____
12.	**Filing Submission Date**	
13.	**Filing Fee (If required)**	Amount $20.00 Check Date _____ Retaliatory ☐ Yes ☑ No Check Number EFT
14.	**Date of Domiciliary Approval**	12-24-2008

15. **Filing Description:**

We have been authorized by Admiral Life Insurance Company of America to file the attached revised Medicare Supplement Application on their behalf. A letter of authorization is included with this filing. The revised Application will replace MSAPP200701AR (SERFF TR Num WKLY-125307727) which was approved by your Department on October 18, 2007. The following changes were made to the application:

(1) Section for the applicant's name was revised by adding (Exactly as shown on your Medicare ID Card);
(2) Sections were added to obtain the date the applicant's Medicare Part A was effective, to whom the policy should be mailed to and when to draft the first premium;
(3) The chart under health question number 12 was revised;
(4) A Primary Physician Information section was added;
(5) Changes were made to the Medical Coverage Replacement section to aid in administration; and
(6) HIPAA required language regarding re-disclosure of information was added to the Authorization section.

Thank you for your assistance with this filing. If you have any questions or require additional information please contact me at 1-877-777-2443, extension 2171or by e-mail at karen.nowlan@Wakelyinc.com.

View Complete Filing Description

16. **Certification (If required)**

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Karen Nowlan Title Compliance Analyst

Signature Karen Nowlan Digitally signed by Karen Nowlan DN: cn=Karen Nowlan, o=Wakely and Associates, Inc, ou=Compliance, email=Karen.Nowlan@Wakelyinc.com, c=US Date: 2008.12.24 11:32:35 -05'00' Date 12-24-2008

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	WKLY-125964883
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Application	ALMSAPP200812AR	☐ Initial ☑ Revised ☐ Other _____	MSAPP200701AR SERFF TR Num WKLY-125307727
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
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12			☐ Initial ☐ Revised ☐ Other _____	

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Overall percentage rate impact for this filing			%	
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01			☐ New ☐ Revised Request +____% -____% ☐ Other _____	
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11			☐ New ☐ Revised Request +____% -____% ☐ Other _____	
12			☐ New ☐ Revised Request +____% -____% ☐ Other _____	

Admiral Life Insurance Company of America
One State Mutual Drive
P. O. Box 33
Rome, GA 30162-0033

February 7, 2008

Ms. Darcey Shaffer, FLMI, ACS
Compliance Manager
Wakely and Associates, Inc.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

Re: Filing/Reporting Requirements for Medicare Supplement Insurance Certificates

Dear Ms. Shaffer:

This letter authorizes Wakely and Associates, Inc. to file on behalf of Admiral Life Insurance Company of America Medicare Supplement forms and rates with the State Departments of Insurance. Also. Wakely and Associates, Inc. may correspond with the State Departments of Insurance regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,

Ann Rogers
Corporate Secretary

Telephone 800.987.1593 or 706.295.1505 • Fax 706.291.9459

Effective January 1, 2006

Life, Accident & Health, Annuity, Credit Transmittal Document (Revised 1/1/06)

Reset Form

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #
Admiral Life Insurance Company of America 2999 N 44th Street, Suite 250 Phoenix, AZ	Arizona	Life and Health	4172	71390	41-6041001

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Karen Nowlan Wakely and Associates, Inc. 8545 126th Avenue, North Largo, FL 33773-1502	877-777-2443, ext 2171	727-584-5613	karen.nowlan@wakelyinc.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain) : _____

6a.	Company Tracking Number		6b.	SERFF Tracking Number	WKLY-125964883
7.	☑ New Submission	☐ Resubmission	Previous file # _____		
8.	Market	☑ Individual ☐ Franchise			
		Group	☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____		
9.	Type of Insurance	MS06 Medicare Supplement-Other			
10.	Product Coding Matrix Filing Code	MS06.000 Medicare Supplement-Other			

11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☑ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☑ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____
12.	**Filing Submission Date**	
13.	**Filing Fee (If required)**	Amount $20.00 Check Date _____ Retaliatory ☐ Yes ☑ No Check Number EFT
14.	**Date of Domiciliary Approval**	12-24-2008

15. **Filing Description:**

We have been authorized by Admiral Life Insurance Company of America to file the attached revised Medicare Supplement Application on their behalf. A letter of authorization is included with this filing. The revised Application will replace MSAPP200701AR (SERFF TR Num WKLY-125307727) which was approved by your Department on October 18, 2007. The following changes were made to the application:

(1) Section for the applicant's name was revised by adding (Exactly as shown on your Medicare ID Card);
(2) Sections were added to obtain the date the applicant's Medicare Part A was effective, to whom the policy should be mailed to and when to draft the first premium;
(3) The chart under health question number 12 was revised;
(4) A Primary Physician Information section was added;
(5) Changes were made to the Medical Coverage Replacement section to aid in administration; and
(6) HIPAA required language regarding re-disclosure of information was added to the Authorization section.

Thank you for your assistance with this filing. If you have any questions or require additional information please contact me at 1-877-777-2443, extension 2171or by e-mail at karen.nowlan@Wakelyinc.com.

View Complete Filing Description

16. **Certification (If required)**

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Karen Nowlan Title Compliance Analyst

Signature Karen Nowlan Digitally signed by Karen Nowlan DN: cn=Karen Nowlan, o=Wakely and Associates, Inc, ou=Compliance, email=Karen.Nowlan@Wakelyinc.com, c=US Date: 2008.12.24 11:32:35 -05'00' Date 12-24-2008

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